PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Pub lic Health Council was held on Wednesday, October 10, 2007, 10:00 a.m., at the Department of Public Health, 250 Washington St., Boston, Massachusetts in the Henr y I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen R. Caulton-Harris, Mr. Harold Cox, Dr. John Cunningham, Dr. Michèle David, Dr. Muriel R. Gillick, Mr. Paul J. Lanzikos, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman (arrived late at 11:30 a.m.), and Dr. Michael Wong. Absent were Dr. Alan C. Woodward, and Dr. Barry S. Zuckerman . Also in attendance was Attorney Donna Levin, General Counsel, Department of Public Health.

Chairperson Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance . In addition, Chair Auerbach welcomed the two new Public Health Council Members: Dr. Meredith Rosenthal and Dr. John Cunningham. The two new members introduced themselves to the audience first, followed by the other Council Members.
Dr. Rosenthal noted that she was a Health Economist and an Associate Professor at the Harvard School of Public Health and further that her background is in "financial incentives for physicians and hospitals, particularly pertaining to the improvement of quality and prevention of medical errors." Dr. Rosenthal fills the seat recommended by the Coalition on the Prevention of Medical Errors. Dr. Cunningham noted that he is Deputy Provost at the University of Massachusetts at Amherst and is filling the spot for the School of Public Health Sciences.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF A UGUST 8, 2007:

A record of the Public Health Council Meeting of A ugust 8, 2007 was presented to the Council for approval. Copies of the minutes were distributed to the Council Members prior to the meeting for review. Dr. Wong made a motion for approval. After consideration, upon motion made and duly seconded, it was voted (unanimously) [except for Dr. Cunningham who abstained from voting and Mr. Sherman who was not present) to approve the Record of the Public Health Council Meeting of August 8, 2007 as presented.

REGULATION: REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 960.000, BIOTECHNOLOGY REGULATIONS:

NOTE: For the record, Council Member Albert Sherman arrived durin g discussion on this regulation; and Members John Cunningham of UMass Amherst and Albert Sherman of UMass Medical Center recused themselves from discussion and voting on this regulation.

Attorney Melissa Lopes presented the request for Final Promulgation of Amendments to 105 CMR 960.000 to the Council. Atty. Lopes said, "…I am here before you today to request final promulgation of the amendments to 105 CMR 960.000, Biotechnology. These amendments

were first presented to this Council on April 15, 2007 and are issued pursuant to Chapter 27 of the Acts of 2005, an Act enhancing regenerative medicine in the Commonwealth, which was enacted on May 31st, 2005. Section I of this Act created a new chapter of the General Laws, Chapter 111L, entitled Biotechnology. This chapter sets for th the General Court's finding that it shall be the policy of the Commonwealth to actively foster research and therapies in the Life Sciences and Regenerative Medicine."

Atty. Lopes continued, "As a way of background, on August 27, 2006, the former Public Health Council promulgated 105 CMR 960.000 under Chapter 111L. With the exceptions of Sections 105 CMR 960.005(A) and 960.006(C)(3), these regulations largely track the statutory language on donation and what is permissible and non-permissible under the statute with regards to research. Written testimony received at the time of the former promulgation by Partners Health Care and the Dana Farber Cancer Institute suggested that Sections 960.005 (A) and 960.006(C)(3) created a cloud of doubt over stem cell research here in the Commonwealth. This cloud of doubt was discussed in subsequent meetings of the Biomedical Research Advisory Council, constituted pursuant to this Act. Further, the concern was expressed by others within the research community. After consideration of these concerns, the Department determined that these sections created an impression that the Act does not actively foster research and therapies in the life sciences and regenerative medicine. Further, the Department determined that this impression created an uncertain regulatory environment for those engaged in stem cell research in the Commonwealth because of criminal penalties attached to this statute, thus clarity is of a particular importance here. Therefore to allay this uncertainty and to clarify that Massachusetts does foster stem cell research, the Department is proposing to rescind 105 CMR 960.005 (A) in its entirety, and to rescind the language 'or using' in 960.006(C)(3). Consequently, the penalty for knowingly creating embryos by the method of fertilization, solely for use in research, will be eliminated in 105 CMR 960.009(A). Additionally, in Section 960.006(C)(3), the word 'knowingly' has been added to further track the statutory language."

Atty. Lopes stated further, "The proposed amendments effectively mark a return to the expressed statutory language in General Laws Chapter 111L, Section 8B, which states: 'No person shall knowingly create an embryo, by the method of fertilization, with the sole intent of donating the embryo for research.'"

Atty. Lopes noted the procedural requirements she followed as required by Chapter 111 L, §10 of the Massachusetts General Laws:

- Published notice 90 days prior to the public hearing. Notice published on May 24, 2007 in the Worcester Telegram and Gazette, The Springfield Union News Republican, the Boston Herald, the New England Journal of Medicine and the Massachusetts Biotechnology Council's web site.

- Concurrent with the public notices, notice and copies of the proposed amendments were sent to the Joint Committee on State Administration and Regulatory Oversight of the General Court, and the Joint Committee on Economic Development and Emerging Technologies. Atty. Lopes said that these committees are authorized to submit comments or proposed changes to the Department regarding proposed or existing

regulations. Neither committee submitted any comments or proposed changes on the proposed regulations.

- The Department held public hearings on the proposed amendments to 105 CMR 960.000 on September 6, 2007 in Boston, Massachusetts and on September 7, 2007 in Worcester, Massachusetts at UMass Medical School. At these hearings, four parties opposed the regulations. These persons included: Father Tad Pacholozyk, Director of Education at the National Catholic Bioethics Center; Evelyn Reilly, Director of the Public Policy for the Massachusetts Family Institute; Mary Sturgis of the Massachusetts Citizens for Life; and Margaret Whitbread, a member of the public and former officer of Massachusetts Citizens for Life. "Much of their testimony stressed the importance of protecting embryos and the availability and successes of stem cell research using adult stem cells, umbilical cord cells, and other non-embryonic sources", noted Atty. Lopes. Attorney Lopes noted that written testimony was received from the following persons/organizations:
    - Melissa Walsh on behalf of Drs. Daniel Podolosky and Pearl O'Rourke of Partners Healthcare. Ms. Walsh's comments stressed that "the Department's amendments would allow vital research to move forward in Massachusetts pursuant to the Legislature's intent in passing the Stem Cell Act."
    - Written testimony to the Department of Public Health from the Greater Boston Chamber of Commerce on September 13, 2007, which supported the Department's amendments,"as restoring the Legislative intent of the Act".
    - On September 21, 2007, the Department received written testimony from Nathaniel Jeansen opposing the proposed amendments as counter to biblical teachings concerning the inception of human life.
    - On September 21, 2007, the Department received written testimony from Daniel M. Avila, Esq., on behalf of the Massachusetts Catholic Conference. Mr. Avila stated, "that the regulatory language, the Department is proposing to rescind, that is prohibiting the creation of a fertilized embryo solely for use in research, was unnecessary in the first instance because statutory reference to donating in Section 8B already prohibits scientists, or anyone else, from researching on an embryo created by the combining of egg and sperm if the creation was done solely to provide an embryo for research that takes the embryo's life."

Atty. Lopes noted that the period for written testimony closed on September 21, 2007 and that all written testimony was posted on the Department's web site, and can be accessed at www.mass.gov/dph. In her closing remarks, Ms. Lopes reiterated her compliance with M.G.L.c.111L§10 and further stated, "In all levels of review, the only concern expressed with these amendments was a concern expressed by members of the public who oppose all manners of embryonic stem cell research…"

Discussion followed by the Council. Council Member Dr. Meredith Rosenthal asked, "Would you give an example of a circumstance that would be ambiguous under the current language that would be clarified under the proposed language?" Atty. Lopes replied, "Certainly, the proposed language is bringing us back to the statute. It is our understanding that the statutory language, which prohibited the creation solely for donation to research, was something that scientists and researchers could understand a little better than the regulations that we promulgated that talked

also about use. We think that this will clarify what they can and cannot do." Chair Auerbach added, "I can give an example where I have heard some of the researchers talk about a particular situation where they were concerned that, if there was research that was being done on a stem cell line, say developed in another state, where the researchers were utilizing stem cells from that state, where they might have been created under certain circumstances, that they were worried they wouldn't be able to actually do the research in Massachusetts using those stem cells and wanted clarity that those could in fact be utilized."

Discussion continued, Council Member Paul Lanzikos asked, "In the testimony received, did you hear from any parties that researchers were, in fact, frustrated in their efforts because of the differences in regulatory and statutory language?" Ms. Lopes answered, "Yes, in this secondary process we only heard from Partners Healthcare, who supported the return to this statutory language; but, in the promulgation of the regulations in the first instance, we heard both from Partners Healthcare and from the Dana Farber Cancer Institute, along with others who signed on to these letters, who are researchers working the field, who felt that the regulations, as they existed previously, created a greater confusion in terms of how they could collaborate across states and how they could perform their work because they felt that there was like a chilling effect upon their work. We also consulted with the Biomedical Research Advisory Council, which was created pursuant to the Act, which is composed of many people that are in this industry, and they also felt the same way, that this could have a chilling effect on research because this research across states is largely a collaborative effort, and internationally."

Dr. Michele David, Public Health Council Member noted, "…In the testimony in opposition of the regulation, there was a sense that it wasn't particularly opposed to that particular striking of that particular clause, but there was opposition to stem cell research in general?" Atty. Lopes stated, "Yes, they do oppose our amendments. They do oppose the striking of this language because they felt that that was some little protection that was provided but they also oppose any type of human embryonic stem cell research. They do not believe that you need to use stem cell lines derived from embryos at all because you can also use adult cells. They presented a lot of evidence of research in the adult stem cell arena." Council Member José Rafael Rivera inquired, "Was there ever any recommendation for alternative language other than what was being proposed by the Department?" Atty. Lopes said, "No, not in any testimony we received. The testimony we received was mostly just either in favor or opposed and saying that we should keep whatever protections we can of embryos."

Chair Auerbach added for clarity, "We are voting on the changes that are highlighted in Attachment 2. It is essentially the elimination of a single sentence, which included the language that didn't exist in the legislation that used the terminology of using the embryo for research. It is really just the elimination of that one sentence to bring this regulation, and make it consistent with what the legislation passed said. We are really simply echoing what the legislation currently is, which was passed by the legislature. Am I correct?" Atty. Lopes replied, "Yes, that is correct." Chair Auerbach further noted, "Just another clarification. That state legislation created an entity known as the Biomedical Research Advisory Council (BRAC) with the explicit purpose of making recommendations to the Department of Public Health with regard to any additional guidance that should govern the research, this type of research. This type of research because both the legislation and the regulation we are looking at, really doesn't have a lot of

specificity within it, with regard to the specific kinds of research questions. The BRAC has been meeting on a regular basis, has it?" Atty. Lopes said, "Yes ."

Atty. Lopes continued, "The BRAC has met pretty regularly, at least four times a year, more recently every two months, they were part of the review process of the original regulations and they had raised some concerns when we received the testimony from researche rs out in the community and BRAC continued to review the regulations after they were promulgated to see if there might be some sort of clarification that we can issue. They have also been involved in the process of reviewing these amendments, and they are in support that it is in line with the statute. They will continue to advise us as we go forward because there are a number of other issues that are important to them, that they feel need to be reflected, either in the statute or in guidance from the Department, and certainly, as this is a changing area of research, we will be working with them closely going forward and, as new technology is developed, we will certainly look to them for guidance in creating the parameters in line with the statute. "

Council Member Harold Cox commented in part, "We have certainly heard lots of things about stem cell research over the last recent period of time, and it seems, as I try to begin to understand the science and begin to understand why we do it and what is import ant about doing it, that it is important to us to continue to be as competitive as possible, and to allow for research to occur, and it seems that, if turning this particular, changing this one line allows for that edge actually to occur, then I am certain ly in concurrence with this…." Council Member Lanzikos asked if the Department heard from any individual legislators about the issue. Atty. Donna Levin, DPH General Counsel replied, "Not during the comment period." Council Member Dr. Muriel Gillick added, "What we are asked to do here is to provide clarification of the statute and it seems fairly straightforward that it does indeed provide that clarification. It would seem to me that, if there are objections to the statute, then the appropriate place to deal with those would be in the Legislature."

Chair Auerbach noted that besides the UMass employees, Dr. Wong will also be recusing himself from the discussion and vote on this regulation. Mr. Harold Cox moved approval of the promulgation of the regulat ion. After consideration, upon motion made and duly seconded, it was voted (unanimously) [except Dr. Cunningham, Mr. Sherman and Dr. Wong who recused themselves from the discussion and vote] to approve **the Final Promulgation of Amendments to 105 CMR 960.000, Biotechnology Regulations**; that a copy of the approved amendments be forwarded to the Secretary of the Commonwealth; and that the approved amendments be attached and made a part of this Record as **Exhibit Number 14,890**.

DETERMINATION OF NEED PROGRAM :

REQUEST FOR APPROVAL OF INFORMATIONAL BULLETIN ON ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS:

Ms. Joan Gorga, Director, Determination of Need Program presented the request to the Council for approval. She said, "I am here to request your adoption of the Annual Information Bulletin, which establishes the Determination of Need Expenditure Minimums. The minimums are increased each year through the use of indices, Marshall and Swift Valuation Service for capital

costs and Global Inside Health Care Cost Review for operating costs. Exhibit A shows the calculations used, and Exhibit B shows the results which will be used for the filing year which began on October 1, 2007. The results are, for equipment for non-acute facilities and clinics, the minimum is seven hundred and sixty thousand, four hundred and forty-two dollars. For total capital expenditures for non-acute care facilities and clinics, one million five hundred and twenty thousand, eight hundred and eighty-six dollars; and capital expenditure for acute care facilities, fourteen million two hundred and fifty-eight thousand, three hundred and fourteen. Projects for capital expenditures with the dollar value below these minimums do not require the filing of a Determination of Need application. Staff asks that you adopt the Informational Bulletin and the Expenditure Minimums for the next filing year."

A memorandum dated October 10, 2007, describing the changes were presented to the Council prior to the meeting. Council Member Albert Sherman moved approval. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the **Informational Bulletin on Annual Adjustments to Determination of Need Expenditure Minimums** contained in the memorandum to the Public Health Council dated October 10, 2007.

EXHIBIT A

ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS

Determination of Need Regulations 105 CMR 100.020 requires the Department of Public Health to adjust expenditure minimums (for inflation).

Capital Cost Indices (Marshall & Swift):

	October 2006	October 2007
Region – Eastern	2539.1	2641.4
Massachusetts	1.10	1.11

$$\frac{2641.4}{2539.1} \times \frac{1.11}{1.10} = 1.049$$

Operating Costs (Global Insight):

	4th Quarter 2006	4th Quarter 2007
Skilled Nursing Facility	1.382	1.433
Hospital	1.412	1.466

$$\frac{(1.433}{(1.382} + \frac{1.466)}{1.412)} /2 = 1.0376$$

EXHIBIT B

ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS

Capital Expenditures

Project Type	October 1, 2006	Filing Year Beginning October 1, 2007
Equipment for non-acute care facilities and clinics	$724,921	$760,442
Total capital expenditure including equipment for non-acute care facilities and clinics	$1,449,844	$1,520,886
Capital expenditure, excluding major movable Equipment, for acute care facilities and Comprehensive cancer centers	$13,592,292	$14,258,314

Operating Costs

Project Type	October 1, 2006	Filing Year Beginning October 1, 2007
Nursing, Rest Homes and Clinics	$673,619	$698,947

CATEGORY 2 APPLICATION: PROJECT APPLICATION NO. 6-3B39 OF NORTH SHORE MEDICAL CENTER, INC.:

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the North Shore Medical Center application to the Council. He said in part, "…The applicant, the North Shore Medical Center, Inc., is before the Council today seeking approval for a significant renovation of the existing space and Phippen and Davenport buildings, along with selected area of the Wheelock, and adjacent to the Emergency Department on the Salem Campus of the North Shore Medical Center. The Medical Center has two campuses, one in Salem and one in Lynn. All of the renovation is going to occur on the Salem campus. The renovation is intended to address the need for improved Medical/Surgical Bed facilities and Intensive Care patient capacity, as well as improvements in some ancillary areas, such as Respiratory Therapy, Administration and the on-call Suite. When the renovation is completed in October 2009, there will be an increase of four Intensive Care beds, from sixteen now to twenty, and a decrease of three medical/surgical beds from 151 to 148. The recommended maximum capital expenditure of $21,196,549 (July 2007 dollars) will be financed in part through an equity contribution of $2,950,000 dollars from fund raising efforts by the North Shore Medical Center. The remaining MCE of $18,246,549 will be provided by Partners Healthcare System. Partners will secure financing with tax exempt bonds

issued by the Massachusetts Health and Educational Facilities Authority. The interest rate is fixed at five percent for 15 years. The financial governance associated with the bond issue will be applicable to Partners. No financial governance will be applicable to North Shore Medical Center.

Mr. Page said further, "In addition, the Medical Center itself will provide a total of a $1,059,827 over a maximum of five years to fund community health service initiatives. $706,551 of the total will go to initiatives that propose to address substance abuse services in Lynn, establish a patient navigator program to address disparities in cancer treatment, as well as establish programming aimed at reducing disparities in the treatment of behavioral health. There will be initiatives to revitalize the Medical Center's Medical Transportation Taxi Voucher program and provide signage in several languages at both the Medical Center's campuses. These initiatives, by the way, were a collaborative effort between the Medical Center and the Leslie Greenberg Ten Taxpayer Group, which represent the Lynn Health Task Force. There is also the $353,275 remaining of that total of $1,059,000 that will go to mini-grants for local programming that have been identified by the Community Health Plan Network area in Salem (CHNA 13/14). The program will be designed to address health disparities and to address chronic disease prevention in the area, as well as provide program support for the CHNA."

In conclusion Mr. Page said, "Staff is recommending approval of the project with the conditions listed on pages 14 and 15 of the staff summary. The applicant is here today to address the Council, as is the TTG, and of course staff would be happy to answer any questions you might have."

Mr. Robert Norton, CEO, North Shore Medical Center, addressed the Council, "…Just to bring everybody up to date, North Shore Medical Center is the largest provider of health care services on the North Shore. We are privileged to be a part of Partners Health Care, which provides significant financial support for the mission and role that we play on the North Shore. We run busy acute care campuses in both Salem and Lynn, and we are the safety net hospital for the North Shore, providing that care to thousands of people in need in the communities. Just to give you a frame on that, we provide north of about 20 million dollars each year of free and un-reimbursed care in providing that safety net role, and we are very proud of the work that we do in that regard…. The project does address really critical needs in bringing our inpatient facilities up to what is a more current standard. Many of our rooms are four-bed rooms and whoever invented the concept, it is certainly barbaric…. This is aimed at making that a different outcome for our patients. We will move through this project and subsequent improvements on the campus to move all of those four-bed rooms to private rooms. The second piece of the project is to take an outdated Intensive Care Unit and convert it to a new Intensive Care Unit, with more contemporary space for our patients – that would be a one bed increase. I will take just a couple of minutes to talk about the Community Benefit proposal…."

Mr. Norton reiterated that $700,000 would go for a suboxone clinic if it is not funded by DPH's Bureau of Substance Abuse Services (Lynn Community Health Center applied for the funding). If the money is not needed for the suboxone clinic then it will be used for both cancer treatment and behavioral health treatment "to try to eliminate some of the disparities that some of our patients and clients receive in those particular areas," said Mr. Norton. He further said, "The

remaining money that we have committed to use will be to improve multi-lingual signage on two campuses, and transportation systems on the North Shore. All of this is detailed in the staff summary."

Ms. Leslie Greenberg, Chair, Lynn Health Task Force Ten Taxpayer Group, testified before the Council. She said in part, "… I am the long term chair of the Lynn Health Task Force. We are a grassroots community group with a diverse membership and, for 22 years, we have been advocating for increased access to health care, especially for immigrants, the elderly, the disabled and others who face barriers in getting medical care…. We are happy to report today that, although the time frame for this process was short, and at the beginning of negotiations, our position was far apart from the hospital's position, we all worked very hard and we came to a point where we came to agreement. Our focus was on the use of the so-called Factor 9 Funds, the funds set aside to address primary and preventative health care needs. Our goals were to address the very high rate of opiate dependence in our community, and overdoses in Lynn, and also to address health disparities in this area. We also wanted to tackle the issue of transportation to medical care, and the multilingual signage at the hospital. We are really pleased that these issues are being addressed in the proposal that you all have before you …. We are very eager to get working on the projects that will be as a result of this DoN, and looking forward to reporting back to you on our progress as the community health initiatives get away, and I would like to thank you all for this consideration."

Discussion followed, Chair Auerbach noted, "It speaks highly of both of the speakers that they were able to negotiate productively to come up with a single proposal that everyone felt comfortable with. I appreciate the work that went into that process." Dr. Michael Wong, Council Member stated, "This is a great proposal and I just want to echo that it is wonderful to see community and organizations like Partners and North Shore working together jointly. Being somebody who works with populations that are highly at risk for substance abuse, and certainly the dual diagnoses associated with this, it is really wonderful to see that there is emphasis on both the suboxone programs and the behavioral disparities, and mental health disparities components." Dr. Wong asked if money for the program would be sustained and if these programs can continue to grow. Mr. Norton, CEO of North Shore Medical Center replied, "I think we recognized the need for this program as a sustainable program. It is our hope that, if the program is funded in its beginning, that it might be continued to be funded. No funding is ever guaranteed, of course, but it is a high priority of ourselves, the Community Health Center and the Task Force, to make sure that that continues in that way. That is why we have sort of reserved a piece of this funding in case even the first round doesn't go the right way. It is a very high priority."

Council Member José Rafael Rivera asked about prevention activities being addressed by this proposal. He was pleased to see suboxone and behavioral health on the table. Ms. Greenberg said, "That prevention is always a big piece of guiding people through the system, the Lynn Health Task Force has always tried to put an educational piece into it. Mr. Norton noted that North Shore has mental health and acute care health case workers in the ER departments to help people hook up with the right services and avoid repeat visits to the ER departments. Council Member Paul Lanzikos, stated, "As a resident of the North Shore, I would be remiss if I didn't echo Dr. Wong's favorable comments about how pleasing it is to see both the medical institution

and the community working together to further the public health status on the North Shore. I would further comment that this Council recently heard a presentation about the increasing concerns around hospital-based infections, and I think what you are proposing here, in terms of the use of private rooms speak well for that objective." Dr. Muriel Gillick noted that it was great that North Shore is providing taxi vouchers. She asked however, given that many elderly and disabled are facing situations where third party payers will not pay for ambulance or a chair car to take them for a medical appointment, would the proposed taxi vouche r program cover other vehicles that provide more assistance to the patient. Dr. Michele David, Council Member noted that some of her patients told her some taxi services refuse to take the vouchers because of remuneration. Mr. Norton replied to both questions, stating that they use taxis but that Greater Lynn Services provide chair cars and other means of transportation. "We will use anything we need to, to get a patient to the right place," he said. And further, "I don't know of any circumstances in our geography where they have refused the vouchers. I think we have been pretty prompt in paying reasonable rates. I think it is working okay in our geography."

Council Member Albert Sherman moved approval. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve **Project Application No. 6-3B39 of North Shore Medical Center, Inc.**, based on staff findings, with a maximum capital expenditure of $21,196,549 (July 2007 dollars) and first year incremental operating costs of $3,109,254 (July 2007 dollars). A staff summary is attached and made a part of this record as **Exhibit No.14,891.** As approved, the application provides for renovation of existing space in the Phippen and Davenport buildings, along with selected areas in th e Wheelock Building and adjacent to the Emergency Department on the Salem campus of the Medical Center. The renovation is intended to address the need for improved medical/surgical bed facilities and intensive care inpatient capacity, as well as improveme nts in some ancillary areas such as respiratory therapy, administration, and the on-call suite. This Determination of Need is subject to the following conditions:

1. North Shore Medical Center shall accept the maximum expenditure of $21,196,549 (July 2007 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 100.752.

2. North Shore Medical Center shall contribute 14% in equity ($2,950,000 in 2007 dollars) to the final approved MCE.

3. The total gross square feet (GSF) for this project shall be 41,326 to renovate four floors of existing space in the Phippen and Davenport buildings, along with selected areas in the Wheelock Building and adjacent to the Emergency Department on the Salem campus of the North Shore Medical Center.

4. North Shore Medical Center shall provide a total of $1,059,827 (July 2007 dollars) over a maximum of five years to fund the community health service initiatives described previously in Section H: Community Health Initiatives.

5. With regard to its interpreter service, North Shore Medical Center shall:

- Continue to inform Limited English Proficiency ("LEP") community members and agencies identified in the Medical Center's service area about the availability of interpreter services at no cost to patients.

- Continue to post signage that informs patients of the availability of interpreter services at no charge in the Emergency Department and at all key points of entry into the Hospital, as required by Federal guidelines. Signage must be available in the primary languages identified by the Hospital's language needs assessment.

- Develop a plan to ensure the inclusion of LEP patients in surveys and mechanisms that measure patient satisfaction and submit it to the Office of Multicultural Health for approval.

- Continue to ensure ongoing training for all hospital clinical staff on the appropriate use of interpreter services, and provide ongoing training for all hospital staff on the appropriate use of interpreter services, inclusive of telephonic services.

- Include the Interpreter Services Director and Coordinators in all administrative decision-making processes that affect people with Limited English Proficiency (LEP)

- Ensure the availability and quality of timely interpreter services at all clinical sites operating under its license.

- Enhance its tracking mechanism system to comprehensively monitor and assess completed patient interpreter requests.

- Ensure that interpreter service policies and procedures are consistent at each of the Medical Center's campuses.

- Develop and ensure that translation procedures and guidance are in place for developing timely, accurate, competent, and culturally appropriate patient educational materials and submit to the Office of Multicultural Health its established procedures for translation of materials.

- If the Medical Center establishes a bank of employee interpreters, develop job protection measures for those employees who will work as trained interpreters.

The Medical Center shall submit a plan to address these interpreter service elements to the Office of Multicultural Health (OMH) within 60 days of DoN Approval, and shall provide Annual Progress Reports to OMH within 45 days of the end of its Federal Fiscal Year. In addition, the Medical Center shall maintain current efforts to provide access to competent interpreter services to LEP patients, notify OMH of any substantial changes to its Interpreter Services Program, and provide to OMH a copy of its annual language needs assessment. Further, the Medical Center shall follow recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. In addition, the Medical Center

must develop a plan on how it will use the data it collects on race and ethnicity to address racial and ethnic health disparities.

Staff's recommendation was based on the following findings:

1. North Shore Medical Center, Inc. is proposing extensive renovation of four floors of existing space in the Phippen and Davenport buildings along selected areas in the Wheelock Building and adjacent to the Emergency Department on the Salem campus of the Medical Center. The renovation is intended to address the need for improved medical/surgical bed facilities and intensive care inpatient capacity, as well as improvements in some ancillary areas such as respiratory therapy, administration, and the on-call suite.

2. The health planning process for the project was satisfactory.

3. The proposed renovation is supported by current and projected utilization, as discussed under the Health Care Requirements factor of the Staff Summary.

4. The project meets the operational objectives factor of the DoN Regulations.

5. The project, with adherence to a certain condition, meets the standards compliance factor of the DoN Regulations.

6. The recommended maximum capital expenditure of $21,196,549 (July 2007 dollars) is reasonable compared to similar, previously approved projects.

7. The recommended operating costs of $3,109,254 (July 2007 dollars) are reasonable compared to similar, previously approved projects.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit requirements of the DoN Regulations.

10. The proposed community health service initiatives, with adherence to a certain condition, are consistent with the DoN Regulations.

11. The Leslie Greenberg Ten Taxpayer Group (TTG) registered in connection with the proposed project and requested a public hearing, which was held on August 27, 2007 in Salem. The TTG also submitted written comments on the proposed project.

PRESENTATION: "EMERGENCY PREPAREDNESS IN MASSACHUSETTS: AN EXAMINATION OF ISOLATION, QUARANTINE AND SOCIAL DISTANCING", BY DR. LISA STONE, HOSPITAL PREPAREDNESS COORDINATOR, DONNA LEVIN, DPH GENERAL COUNSEL, AND PRISCILLA FOX, LEGAL CONSULTANT:

Chair John Auerbach, Commissioner, Department of Public Health made introductory remarks, "…We are on to a portion of the meeting which will discuss an important Public Health issue, one which has importance to all of the residents of the Commonwealth, but also involves discussion of a particular role of the Public Health Council in the event of a major public health emergency. We are going to hear from two members of our General Counsel's Office, Donna Levin and Priscilla Fox, about specific laws that involve aspects of the issues of emergency preparedness, specifically around issues of social distancing, quarantine, isolation, curfews, etc. Ms. Levin will be explaining the particular aspects of that. "

Attorney Donna Levin, DPH General Counsel began the presentation. She noted that at the request of the Centers for Disease Control (CDC) and the Association of State and Territorial Health Officers (ASTHO) the Department conducted a review their legal authority and social distancing measures (i.e., isolation, quarantine, curfew and closing of public gatherings during a public health emergency such as a pandemic flu).

Atty. Levin said in part, "…We found that although some of our law is archaic, and there is an initiative here in the Legislature to try and modernize that, and make it more cohesive and consistent, we basically do have the legal tools that we need, and the bottom line after the meeting seemed to be that we just needed to make sure we are coordinated in how we go about that." Atty. Levin gave an overview of the presentations to follow: Dr. Lisa Stone will speak about Pandemic Flu; Donna herself will speak about some broad concepts with respect to declaration of a Public Health Emergency in the Commonwealth. She would also speak a bit on isolation and quarantine. Priscilla Fox will address what we can do in the absence of a Declared Emergency, and focus on isolation and quarantine. Atty. Levin noted that DPH has the ability to declare an emergency with or without a Declaration of Emergency. Some excerpts follow from their presentations:

Dr. Lisa Stone, Hospital Preparedness Coordinator, "I am going to attempt to paint a picture of what a pandemic might look like in Massachusetts and along the way, I am really only going to talk to you about a fraction of our planning…. The definition of a pandemic is a global epidemic. It is an epidemic that affects the world's population essentially at the same time. It requires the emergence of a novel influence of virus, a virus that the world's population has not been exposed to before, leaving the world's population vulnerable, and also a virus that is capable of effective human-to-human transmission. Until you have both of those characteristics, you can't achieve a pandemic."

Dr. Stone continued, "In Massachusetts, according to our planning assumptions, we anticipate that, should a virus emerge with pandemic potential, that we should likely have

two million people in our population that would actually get the flu. That is a thirty percent attack rate; and, of those people that would get the flu, approximately 80,000 would need hospital level care, and we would have around 20,000 deaths within the Commonwealth…. In Y2K, we were concerned about the loss of the communicat ion information sector. Under a pandemic influenza, we are concerned that we will lose our work force – not just in health care but across all of the sectors. That is what characterizes the planning around this pandemic."

Dr. Stone said further, "We kno w that the healthcare sector will be quickly overwhelmed, and we know that this will result in lots of scarce resources for which we need to do some very careful planning and preparation; but, like all influenza epidemics, it will follow roughly the same curve as seasonal flu, and this is last year's subtypes of influenza outbreaks in the United States, and you can see that all follow an epidemic curve, where you start from the baseline, build to a peak, and then come back down. Therefore, much of our plan ning for a pandemic is built around the impact we anticipate at the very peak of that epidemic curve…. We know that we need to anticipate that this virus, once it emerges, will spread across the country, and across every single community in Massachusetts essentially simultaneously."

Pandemic Challenges:

- High rates of absenteeism (due to illness and caring for others)
- Fear and anxiety about going to work
- Continuity of Operations/Continuity of Government and Financial Survivability Planning is key
- Order and security will be disrupted for several months, not just hours or days
- Media portrayal, mal-alignment of triggers

Dr. Stone continued, "These key challenges led a statewide effort around continuity of operations planning with all of our provider organiza tions, and we are also working with Public Safety and many other partners, to make sure that people are doing continuity of operations planning, and that really is essentially the identification of the essential services that people have, that must be cont inued, even in the midst of a pandemic, and how they will manage to provide those services during that time. We have concerns about order and security. Much of our planning in the response to the pandemic will require a cooperative public, a public that understands the measures that are being taken, why they are being taken, and the purpose behind them, and our ability to maintain social calm and order will really be an important determinant of how well we respond to a pandemic. We are very dependent on many factors for our supply time, and we live in a Just-in-Time economy today, so that means that most places, including the grocery stores, pharmacies, ATM machines, and just about anything you can think of, requires constant re-supply for that to be avai lable to us. Because of absenteeism in the work force, we have to expect that all of these things that are required to bring the goods and the services to our door, and make them available to us, will be disrupted, and it won't take very many missed deliveries of any kind for the shelves to look like this very early in a pandemic… ."

Healthcare Sector Challenges:

- No surge capacity in system today
- Despite operational changes, hospitals will be unable to provide care to all those who need hospital level care
- Flu patients that cannot be admitted to hospitals will be cared for at home or in community based alternate care site, or influenza Specialty Care Units (ISCUs)
- Scare resources, particularly staff, will result in an altered standard of care and allocation of resources

Dr. Stone said further, "Our scarcest resource is going to be staff, and that is really our greatest concern at this time. And as difficult as it is to imagine taking care of all of the very sick people that will need hospital level care, the reality is that the impact is really going to be felt in the communities, and because every community will be responding at that same time, we know that the state will be limited in its ability to respond to each and every community, and that we need to do a lot of work to make sure that our communities are prepared, as prepared as possible to meet the challenge. The two million people that we anticipate will actually get the flu (based on CDC assumption) that says that half of those people are likely to not need clinical care and evaluation. They may need lots of other assistance with supply chain issues, and needing other kinds of services, but we don't believe we will need to have them clinically evaluated and care for. They will have a very mild case similar to seasonal flu and may be out sick seven to ten days and then return to work… . Then we have 920,000 people over the course of the wave, the entire epidemic curve, who we believe are going to be sick enough that they will require clinical care and follow-up care, evaluation, and our challenge really is to do our very best job that we can to provide access to care to those people because the reality is, if we are not able to do that, they will become sicker. They will push up into the hospital sector of people needing care further stressing the entire system. Therefore, these pieces need to work very collaboratively together."

Dr. Stone reiterated: "The goals here are to do three things:

- Delay onset of the pandemic
- Decrease the peak of the epidemic curve
- Reduce the total number of cases that are under the epidemic curve."

"And this is how you do it," she said, "You just don't go near people who are coughing because the virus is transmitted by droplets, and the droplets are fairly heavy, so they deposit within a fairly short distance, and they don't live long outside of the body. If you can keep yourself away from the droplets that is really the key to prevention with the pandemic."

Mitigation: Individual Measures:

- Personal Protective Behavior (PPB)
  - Cough etiquette
  - Dispose of tissues properly

- Avoid public gatherings
- Keep three feet from ill persons
- Voluntary isolation and quarantine

- Self-shielding

  - Voluntary isolation and quarantine
  - Workplace policies
  - Avoiding crowds: working/shopping/health care access and delivery

Mitigation: Community Measures:

- Social distancing
  - Cancellation of public events
  - Closure of recreational and other facilities
  - Closure of schools
  - Closure of businesses

- Travel restrictions, curfews and other restrictions of movement

Dr. Stone noted that Massachusetts has a school closure policy in Massachusetts. She said the reason the schools would be closed for two to four weeks in the midst of the pandemic is because children relate to each other in ways that adults tend to not relate to each other. We don't stand in line the same way they do, or share our personal space with others the way that they tend to.

School Closings:

- Community Containment Strategy
- Influenza transmission is driven by children
- Children experience infection earliest, transmit the virus longest and have the highest attack rate

"In closing," Dr. Stone stated, "The moral of the story with a pandemic is that, ultimately, the toll a pandemic is going to take on each one of our communities is going to be a direct reflection of the level of that community's preparedness, and the effective use of these community containment measures." Dr. Stone showed a slide with the 1918 Spanish Flu pandemic that tells the story of two different communities, Philadelphia and St. Louis. "You can see the dramatic differences in impact that the pandemic had on those places," she said. "The story behind this is, when St. Louis started experiencing cases, they immediately instituted their community mitigation measures. This occurred during a time of war, and soldiers were returning home from war. Philadelphia had a very important returning home from war parade scheduled, just as they started to experience cases, and they debated, but they decided to wait until after the parade to institute their community containment measures, a two-week delay which resulted in the difference of impact. Keep this in mind as you think about what messages you might want to

take back to your own communities where you live and your own work places where you work, about the importance of these measures."

Attorney Donna Levin began her presentation with a quote from Wendy Parmet, Professor at Northeastern Law School:

"When plague threatened, the law was the chief mechanism to support Public Health. Whether they relied on the enforcement of maritime quarantines or on the establishment of PEST houses, people have invariably depended on law's ability to structure responses and to enforce norms in response to Public Health threats. Indeed, in times of crisis, the most potent variable distinguishing the community that survives plague from that which does not is the degree of scientific knowledge possessed by the community, but rather the responsiveness and stability of the legal system. Thus, in the late nineteenth century, cities in the United States that had established well organized boards of health, and had granted the requisite of legal authority were far better able to endure the threats of cholera and other epidemics than were communities that lacked the legal structure to respond."

Atty. Levin said, "…Science is the key the more we know about the disease, the better able we are to fight it, but the point is that the science and medical knowledge alone is not enough, we need the legal authority and structure to respond…. The Tenth Amendment of the United States Constitution reserved all powers not given to the Federal Government to the States, and the States have traditionally had a great reservoir of authority with respect to public health. It is called the Police Power, and it is a power to protect the health, safety and welfare of the population. Therefore, a lot of this falls to the States, and the States have the authority to delegate this power to local cities and towns; and so state and local cities and towns are partners in this, and when you hear from the Federal Government on this, as we did in fact with this project, the message is, states, you must be ready. We will be there in some way, shape or form, but this responsibility largely falls to you."

Atty. Levin continued, "This exercise of power is limited by rights of individuals under the Constitution and these rights of individuals come into play front and center when you are talking about social distancing. You have rights such as liberty, privacy, autonomy and religion. This slide pairs individual rights affected by social distancing measures that the State may impose:

Individual Rights: Rights Afforded under Constitution v. State Authority
• Privacy/Autonomy/Confidentiality vs. Examination, Testing, Vaccination
• Exercise of Religion vs. Prophylaxis against Infectious Disease; Curtailment of Religious Gatherings
• Freedom of Association vs. Prohibition of Public Gatherings; Curfew
• Liberty vs. Isolation and Quarantine
• Due Process/Procedural Protections vs. State Need for Summary Action

Ms. Levin cited other laws regarding the public health in an emergency:

Jacobson v. Massachusetts (U.S. Supreme Court – 1905)
• Upheld exercise of police power to compel citizens to be vaccinated for smallpox
• Restriction of liberty/autonomy appropriate only when necessary to prevent avoidable harm and only when it imposes no harm
• Balance – measure must use reasonable means and be proportional to the public health problem

Public Health Emergency: M.G.L.c.17, §.2A
• Upon declaration by the governor that an emergency exists which is detrimental to the public health, the commissioner may, with the approval of the governor and the public health council, during such period of emergency, take such action and incur such liabilities as he may deem necessary to assure the maintenance of public health and the prevention of disease.

Atty. Levin spoke about the above Massachusetts law, requiring the approval of the Public Health Council for the Commissioner of Public Health to take action in a public health emergency. She said in part, "One potential issue is the constraints of the Open Meeting Law on the Public Health Council. If 30% of the population is going to be sick, and if that 30% is you, maybe we would be all right because a quorum is eight. However if some of you want to stay home with your families, you know, there are real problems here; and, as we know, we are not supposed to meet by phone, and we are supposed to have a corporal convening of our bodies in the room. This is something we need to think about and it may be a real problem in the context of a real emergency. There are different perspectives and proposals regarding the feasibility of obtaining PHC approval at this time, and there are some proposals in the Legislature, that we can talk about, and get your sense of."

Atty. Levin continued, "The way this would be done, as a practical matter is, the exercise of this authority under the declaration of Public Health Emergency would be implemented through orders of the Commissioner. The orders would set out the rationale and the basis for the order, the authority, the duration if we knew, due process protections where they are applicable, and the manner of enforcement, and these are the kinds of potential orders:

- Closure of Facilities
- Isolation and Quarantine
- Closure of Public Assemblies and Public Transportation
- Medical Evaluation

- Mass. Prophylaxis

Order for Mass Prophylaxis:
• Allows standing order of state medical director to serve as prescription
• Antivirals dispensed at pharmacies
• Possible mandatory vaccination (if available) by providers outside the standard scope of practice
o Exception for those with medical contraindication or religious objection
o Possible quarantine for those who object

Atty. Levin talked about the need to be careful when it comes to isolation and quarantine and to avoid any discriminatory practices. "How should quarantine and isolation requirements be implemented?" She continued, "It is really clear that a voluntary approach has to be the first approach, and that trust is going to be key. So the SARS experience, in Toronto, this voluntary approach worked. If you look at the numbers, thirteen thousand who received orders comp lied and in the end, there was only one formal appeal. Twenty -seven required a formal quarantine order, and it is questionable whether the system could have handled this any other way. The exercise of legal authority is key but realistically, mass non -compliance will not be manageable by Public Health and Safety au thorities or the court system."

In conclusion, Atty. Levin stated, "I come back full circle to where I started and end by saying that the law has its limitations. The authority must be there. We must research, discuss, agree and understand how it would be exercised. It is absolutely essential, but communication, education, transparency are key, and the public is going to have to have trust in their Public Health authority, trust that the deci sions are reasonable, well thought out, protective of Public Health and implemented equitably."

In one final note, Atty. Levin said, "What does this mean for the Public Health Council? The PHC role in the statute is to approve these important actions and procedures, and also to approve liabilities incurred and, as I referred to earlier, there may be a problem with getting a quorum on this. We are going to need your contact information for sure, until and unless the statute changes in this regard and also to bring you more information and training on this."

Atty. Priscilla Fox addressed the Council in regard to the legal authority that the Department of Public Health has in the absence of a declared emergency. Some excerpts follow:

- DPH has the authority to define which diseases are dangerous and create regulations to control and prevent those.

- DPH has coordinate powers with the Local Boards of Health and Health Departments in every city/town in Massachusetts.

- DPH has a very important power, which is to implement and enforce the isolation and quarantine requirements. For example, keeping a food handler with Hepatitis A out of work for a certain period of time until they are no longer infectious is often done by the

local health authorities. People voluntarily comply.

- Local Health Authorities have broad powers, legal powers at the local level to make reasonable health regulations.

- Chapter 111, §104 gives broad authority and states that health authorities shall use all possible means to prevent the spread of infection of dangerous diseases that specifically relate to localities. They may cause a sick or infected person to be removed to a hospital if they cannot be effectively isolated at home.

- If a person will not voluntarily comply with an isolation order, the Department would use the least restrictive alternative (i.e., least restrictive on someone's liberty) that achieves your Public Health goal of protecting the public. Ideally, DPH would want the people to be isolated or quarantined in their homes, if a home is available and they are willing to stay there. If they are homeless or unwilling, the Department would designate a facility and that could be enforced by the State or Local police.

- Due process protection allows the person quarantined in the home to make a telephone call to a Public Health Official to appeal the decision. In a facility, the Department would get a court order authorizing the detention, the isolation and quarantine as soon as possible.

- State has been providing training programs around the state. During the SARS outbreak a program called the "Legal Nuts and Bolts of Isolation and Quarantine" was developed, containing templates for legal papers, based on a hypothetical case of SARS. It contains complaint affidavits and motions that would be filed in court.

- A second training has been very successful for training of police and Public Safety authorities. It is called "Infectious Diseases and Emergencies Training for Public Safety."

- Community Care-Taking Function by Police is to give immediate aid to people and prevent harm (not limited by fourth amendment-like law enforcement activities). Community Care-Taking includes: forcibly enter private premises to locate victims and render medical treatment, contain and neutralize harmful agents on public property, or forcibly isolate people or property that pose a serious threat to others, or mandate the evacuation of a building, if necessary to protect the occupants or others.
- If a riot or civil disorder occurs or is threatened, a local municipality may impose a curfew, and they can do that very quickly through formal proclamation, and then it takes effect two hours later.

- The Massachusetts Association of Health Boards suggested that a local health authority could issue a curfew under the Nuisance Statute (i.e., to get around the Open Meeting Law issue).

- Mutual Aid: on the State level, during declared emergencies, there is the Emergency Management Assistance Compact. All fifty states are members and aid is sent upon request. This was used a lot during Hurricane Katrina. Many states sent personnel and material resources. This is limited to state employees so you can't send people from the private sector.

- New England State Police Compact allows states to send each other state police officers if needed.

- International Emergency Management Assistance Compact, which include the six New England states and five eastern Canadian provinces. This allows aid across international borders. This does not require that an emergency be declared. Congressional consent is required. (Legislation still pending in US. House and Senate.)

- M.G.L. Ch. 40, §4A authorizes mutual aid between local health agencies. A template is available, which has been adopted by some municipalities and authorized by many.

Chair Auerbach noted, "It is clear that you have done an amazing job in terms of helping us prepare for a major emergency and, as Dr. Stone said, this really represents just a small amount of the preparations that have gone on throughout the Department of Public Health…."

Discussion followed by the Council. Dr. Michele David noted, "…Sometimes medical personnel may be overwhelmed and unable to render aid and need help from other states but medical personnel are not licensed across states. How do we address that issue?" Atty. Fox replied that, "There is a Massachusetts System for Advanced Registration (MSAR), authorized by Federal Law and Massachusetts has received funds to set it up. It is a system of advanced registration, where we can precredential, precheck doctors, and nurses and eventually we will expand this to many other categories of health professionals. We can put the names in a database and call them up as the need arises."

Atty. Fox continued, "The issue of crossing state lines is a very important one, and currently there is no way to send them with liability protection or licensing authority across state lines. There is pending legislation in the Legislature right now that would allow them to have liability protection across the state lines. Licensure would still be an issue and licensure might have to be waived or there would have to be reciprocal licensure by a state needing help. For example, during Hurricane Katrina, the Louisiana Governor issued an Executive Order allowing doctors from other states, who had a current license in good standing, to practice in Louisiana."

Atty. Fox said further on the physician licensure issue, "There is another effort on the National level – a fifty-state effort. There is a group called Commissioners for Uniform State Laws. The idea is you get a law that all 50 states are encouraged to adopt and then they can all exchange things. The Uniform Emergency Volunteer Health Practitioners Act would allow the sharing of private sector health care professionals across state lines and would grant reciprocal licensure and liability protection…. A new effort to be looked into."

Dr. Harold Cox, Public Health Council Member said in part, "…I would encourage you and the Department to actually think about how we can actually step up, ramp up that whole business of helping local public health, as well as, I am unclear right now about what the legislation is that Representative Koutoujian has been working on, but that also has some issues that certainly need to be worked out because I don't think that the legislation is quite in sync with some of the other activities that are going on. We recognize the importance of mutual aid, and certainly recognize the need for the Department to continue doing what it is doing, but also ramp it up some, as well."

Council Member Lucilia Prates Ramos noted, "You have mentioned that there is training, ongoing trainings; and in fact, there is going to be a training in the Merrimack Valley area, which is where I have my office based, and I am happy to hear that, and that communication is the key. And I sit here and I listen to all of this, and I think, well, how are we communicating this to limited English proficient populations, and to our homebound populations? How are they learning about this? I can envision the police knocking on an immigrant's door and them being frightened to death about, why are they here? Why are they knocking?"

Dr. Lisa Stone responded, "That's a very important question. I will tell you where we are now. Public communication has to be done very carefully. One thing we know is that hysteria and getting the public overly concerned can work against us, and not providing enough information can also work against us, and there is really a very fine line between the two, as I think we have certainly seen at the national level. In terms of populations that may have some informational barriers to access of all of this, we have established that as a priority project moving forward this year. We launched our very first campaign around pandemic preparedness last fall, which we did do in a number of different languages, and it included brochures, posters on the MBTA, and buses, and worked through a variety of different vehicles to get it to those populations. We clearly need to do a lot more, and that is something that we have dedicated funding, personnel, and have prioritized as a project moving forward, to make sure that we access all of those populations...."

Chair Auerbach added, "I would add a couple of other things that I know are going on with federal funding from DPH. We specifically address that issue by funding grassroots organizations that were population and language specific to be trained in Emergency Preparedness in general, and Pandemic Influenza Preparations in particular, where the organizations that actually worked in the specific communities were given the information, and then funded to do culturally appropriate presentations in different languages within their communities; very much grassroots. They were relatively small grants, but they mobilized important organizations and communities to feel a part of the process, and also to raise some of the issues that were specific to their communities so that those issues could be addressed. That kind of approach hasn't been expanded statewide, but I think that it offers a model of how to actually fully engage the populations that are affected in the process, and give them the tools to reach the communities that they are especially skilled at reaching."

Council Member Dr. Michael Wong noted that while he was in Spain recently, he noticed that there was a lot of public messaging around respiratory hygiene (cough and sneeze hygiene). "Are

there, aside from the grassroots efforts, are there larger efforts to try to make this much more public?" he asked.

Dr. Stone stated, "One of things that we know is effective is to use seasonal flu as a mechanism to educate the public about those measures that will also be important in pandemic flu because, really, it is the same disease; and health care providers have instituted, in their offices, information around cough hygiene and etiquette, ad the use of masks, and that kind of thing. We are rolling out this fall, a program that has been developed by the Department, called 'Caring for a Flu Patient at Home', and it is targeted at the lay audience. It is going to be presented in a variety of media and languages, and in a number of different ways that will also, again begin to just transmit that general prevention information that will protect people both for seasonal outbreak, as well as for pandemic outbreak."

Dr. Michele David, Council Member stated, "I tend to notice that, whenever there are emergencies and declaration that are made to the press, that Public Health tends to engage mainstream media. There is a huge amount of ethnic media, and they can relay that information because usually the Limited Proficiency Language population doesn't listen to mainstream media. Do we have a plan to engage different language media, and they are kind of small Mom and Pop type of operations, so it requires a lot of communication with them to reach them."

Dr. Stone replied, "In fact, the Department of Public Health has a wealth of resources for just that kind of thing. One of things we are looking to do, is to use our own strengths, our own resources and what we know about reaching those populations over a whole range of Public Health issues, and specifically around beginning to bring emergency preparedness information through those vehicles that are already very well used and well understood ways to reach other populations."

Council Member Paul Lanzikos noted in part, "…It sounds like the Department is gearing up to do additional efforts. I would make sure that the right personnel are there. I think executive directors or agency heads definitely need to be there, but we need to make sure that the front line staff are there too and more importantly that the contact continues on an ongoing basis. We could be doing other measures; for example, respiratory hygiene could be, twice a year, we could repeat that because, if you don't have that regular contact, frankly, a lot of the day-to-day business of our organizations take precedence, and this falls into the background."

Atty. Donna Levin added for the record, "It is probably wise to mention that in addition to declared public health emergency, there is also a State of Emergency that can be declared by the Governor, and actually both can be declared at the same time and MEMA then takes charge and Public Health will be at the State Emergency Operations Center (known as the Bunker). "

Discussion continued; please see the verbatim transcript for further and full discussion. Chair Auerbach said, "…I am going to ask us to spend a few minutes on this other matter, and it is the concern that Donna raised, that if we were in a situation of a Declared Public Health Emergency and we did have to respond with exceptional action steps, the current laws in the Commonwealth require that, before I could take action as Commissioner in a Governor-Declared Public Health Emergency, we would have to have an in-person meeting of at least eight of the members of the

Public Health Council, and this is a law that was written a long time ago. We are worried about how feasible it is, that we could quickly convene at least eight of you to come to a location, given that the law does not, we believe, allow for telephone communication."

Chair Auerbach asked, "If there are quarantined-off areas, how would the PHC members get through? You are stopped like anyone else. There are difficult obstacles to getting people together, not to mention the fact that you might be sick or concerned with your own families, or have your own jobs that you have to report to. This is simply acknowledging this as a question and maybe soliciting from you whether or not you feel like those are things we can overcome or things we should try to talk to the Legislature about, to try to address."

Council Member Mr. Albert Sherman noted that Public Health Council Members are not considered critical state employees on the ID badges and that that needs to be changed by Executive mandate. Council Member Harold Cox added, "I am certain in an emergency, we will all show up Commissioner Auerbach. I just know that already. However, for those who just can't and won't, I like the suggestion by MAHB, of using the health agent to act for the board. I am wondering if a similar kind of measure is being considered here, where the Commissioner would act for the Board. We will all show up for duty but just in the event that we didn't and you did, that you acting for the Board, and reporting back to the Board, if that is a measure that can be considered for this kind of emergency, as well."

Chair Auerbach noted that Mr. Cox's suggestion above would take a legislative change. Atty. Donna Levin, Deputy General Counsel for DPH, stated in part, "I think, absent of having the statute changed, I would rather have that than nothing. I think that is something that we should try. I think, when we look at it here, and look at the obstacles, we think perhaps, it is best not to have the PHC formally in this role, but obviously the PHC is there, and can be consulted by the Commissioner. If we can get the Council together, that is one thing; phone call to individual members is another, to get guidance; but to have that in the statute, in a really horrific time it is an obstacle that, to be candid, I think we would have to do what we have to do, by telephone if necessary, without a quorum, if necessary, without the approval if necessary, with the Commissioner working in concert with the Governor and other authorities, but it is worrisome to us."

Council Member Paul Lanzikos said, "During the presentation, some of you made reference to the importance of trust in the communication process, and I don't think we should minimize that. In fact, I think that is probably going to be one of the most important resources that the Government as a whole and the Department, will have; and to that end, I think that however the Council could be involved, at least in an advisory or consultive fashion, should be maintained. I think at this point, to totally remove it, probably could have the potential of eroding or putting in jeopardy that trust."

Dr. Lanzikos said that on a good day it is hard to travel into Boston and that it took him 90 minutes to get to Boston from Salem, MA on a good day. And added, "In this day and age, communication is much different than when any of these statutes were written. Back then, only two people could talk on the telephone at one time. Now, we can have worldwide conferences with hundreds of people. I would encourage changes in legislation to allow electronic

communication, whether it is telephonic or through the Internet, or some set of mechanisms and to also modify the requirement so it is not obligatory that the Council is the whole act, but continue to be responsive and to work with the Commissioner whenever possible."

In conclusion, Chair Auerbach added, "Thank you for those thoughtful comments. There is legislation that is under consideration, that has been filed by Senator Moore, which is looking at these issues and is attempting to address some of those issues, and we will take the collective from the Council about your thoughts about the ways to best utilize your involvement as we have the discussions with the Senator, and we think about other approaches. It would seem to me that this is an issue that we will need to come back to the Council for in a future meeting. We may want to highlight some of the other challenges in terms of emergency preparedness, that we didn't touch on today, but we also will want to come back to you with our recommendations for how to involve you in the event of that kind of emergency, and what we think the best approaches are and what, strategies we have to come up with, at least on an interim basis …."

No Vote Information Only

The meeting adjourned at approximately 12:15 p.m.

_____

John Auerbach, Chair

LMH/lmh